Minimising Gambling Harm in South Australia: Investment Plan 2021–26

Monitoring and Evaluation Framework

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human services

THE UNIVERSITY of ADELAIDE

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Minimising Gambling Harm in South Australia – Investment Plan 2021–26

Purpose of the Investment Plan 2021–26

Preventing and minimising gambling harm is a key government priority in South Australia. With the community losing around $1 billion to gambling in 2018–19, and no observed change in the proportion of South Australians engaging in risky gambling, the Minimising Gambling Harm: Investment Plan 2021–26 (the Investment Plan) was developed as a coordinated and strategic response to gambling harm in South Australia (Department of Human Services [DHS], 2021).

A Theory of Change Framework for minimising gambling-related harm shaped the design of the Investment Plan and its Strategic Priorities (The Australian Centre for Social Innovation [TACSI], 2021). The Investment Plan was developed from a review of data and academic literature, a review of policy directions in national and international jurisdictions and through consultations with the community and industry, including people harmed by gambling.

Informed by a public health approach, the Investment Plan was designed to reflect the breadth of factors that influence gambling harm (DHS, 2021). A public health approach emphasises prevention by promoting healthy behaviour across a community and recognises that various interventions, delivered through a range of sectors and settings, are needed to reduce gambling harm.

For both industry and the community, the Investment Plan identifies opportunities to partner with government and to contribute directly to efforts to better protect South Australians from gambling harm (DHS, 2021).

Six projects within the Investment Plan

The Office for Problem Gambling (OPG) is in the process of implementing six key projects under the Investment Plan.

These reflect outcomes of its consultation process and are consistent with recently reformed legislation. New elements will be developed in each year of the Investment Plan (2021–26) (DHS, 2021).

The Key Performance Indicators (KPIs) developed as part of this Monitoring and Evaluation Framework (MEF) have also been aligned with these six initial projects, such that their implementation and impact can be measured. As additional, subsequent projects are rolled out, they too can be mapped onto the MEF.

The investment plan

VISION

South Australians talk openly and honestly about gambling harm and take steps to prevent and address it.

All South Australians who choose to participate in gambling can do so safely.

GOAL

South Australians are more likely to access help:

- for their own or someone else's gambling
- before experiencing crisis
- so they are less likely to relapse.

STRATEGIC PRIORITIES AND FOCUS AREAS

South Australians recognise gambling harm and know how to help

- Educate at-risk groups about risky gambling behaviour and how to keep themselves safe, gambling-related harm and the help available.
- Arm South Australians with the knowledge, resources and skills to minimise and prevent gambling harm.
- Deliver culturally and linguistically appropriate messaging about the impact of gambling harm on individuals, families and the community, and promote help seeking.
- Challenge negative community attitudes, common misconceptions and stigma about gambling products, behaviour and harm.

Preventing and intervening early in gambling harm

- Develop targeted prevention and early intervention initiatives for those groups most at risk of experiencing gambling harm.
- Build workforce capability and capacity for harm prevention and to recognise and intervene early in gambling harm, including among venue staff and allied services.
- Support communities to offer diverse, pro-social leisure activities as an alternative to gambling.
- Help grow the evidence base for effective prevention and early intervention in gambling harm.

People get the right support at the right time

- Ensure people experiencing gambling harm have access to a range of client-centred, culturally appropriate resources, services and support.
- Equip loved ones with the knowledge and skills they need to engage in appropriate self-care and minimise harm.
- Establish clear referral processes and pathways to and within the gambling help service system.
- Identify and address system-level barriers to accessing and benefitting from gambling help services.

An agile system equipped to identify, prevent and respond to emerging harm and need

- Partner with the regulator, help services and industry to create safer gambling environments.
- Contribute to local and national efforts to design and implement coordinated action to prevent and minimise gambling harm.
- Disseminate information and research to empower community participation in debate around gambling harm and decision-making at the local level.
- Fund and promote research to inform gambling harm prevention and minimisation policy, initiatives and decisions.

Gambling harm in South Australia

In 2018, almost one in five (19%) South Australian gamblers reported at least some form of gambling-related harm in the previous 12 months (based on any type of reported gambling harm) (Woods et al., 2018).

In 2018, analysis of the Problem Gambling Severity Index additionally showed that 57.2% of South Australians were non-problem gamblers, 4.6% were low risk gamblers, 2.2% were moderate risk gamblers and 0.7% were problem gamblers (and 35.3% were non-gamblers).

Across the South Australian adult population, at-risk gambling (problem and moderate risk gamblers) is significantly over-represented in the following population segments (Woods et al., 2018):

Men (4.1% were at-risk gamblers vs 1.8% of women)

People who are **unemployed** (5.4%)

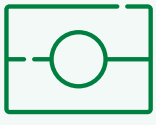
People on the **lowest household income** (4.3%)

Single respondents (4.8%)

People who are **divorced or separated** (4.0%)

Young people aged 18 to 24 years (4.5%)

People speaking a **Language Other than English** (LOTE) at home (4.2% vs 2.8% who only spoke English)



Aboriginal people (5.6% vs 2.9%)

People who had **gambled on the internet** during the past 12 months (9.6% vs 3.2% of non-internet gamblers)

Help seeking for gambling harm

In spite of the significant harms caused by gambling, only just over one third (36%) of problem gamblers sought help for a gambling problem in 2018. In addition, only 15% of problem gamblers self-excluded from venues and 4% became excluded by others (Woods et al., 2018).

This suggests that many individuals and families within the South Australian population are likely to be experiencing gambling harm and may benefit from activities undertaken as part of the Investment Plan (DHS, 2021).

Monitoring and Evaluation Framework

The Monitoring and Evaluation Framework (MEF) will be used to evaluate progress made in achieving objectives within each Strategic Priority of the Investment Plan.

Key Result Areas (KRAs), Key Performance Indicators (KPIs) and Key Performance Measures (KPMs), have been developed for this purpose.

Monitoring and evaluation time frames and activities

Monitoring and evaluation activities will be undertaken annually to measure the overall progress made in achieving the strategic priorities of the Investment Plan. Progress will also be reported annually following conclusion of the monitoring and evaluation activities.

Specific monitoring and evaluation activities used to monitor progress against the KPIs and KPMs set under the MEF will include:

- Conduct of population surveys
- Conduct of smaller scale surveys (e.g., staff of Gambling Help Services)
- Analysis of the Client Data Set (the data which Gambling Help Services enter as part of their funding agreements)
- Qualitative discussions with stakeholders across the Gambling Help service system in South Australia
- Analysis of other types of business data and metrics (e.g., campaign evaluation data, metrics from communications campaigns etc.).

Methodology used to develop the Monitoring and Evaluation Framework

The current Monitoring and Evaluation Framework has been developed based on consideration of the objectives of the Investment Plan (DHS, 2021) and consideration of relevant literature and leading research evidence highlighting the key activities that underpin a highly-effective harm-minimisation service system.

The methodology used to develop the Framework included:

Review of evidence and scientific literature relating to each Strategic Priority of the Investment Plan

Analysis of key issues of relevance to activities associated with each Strategic Priority within South Australia and its gambling harm-minimisation service system

Informal discussions with stakeholders to gather feedback on key needs, issues and possible directions for monitoring and evaluation within the service system.

South Australians recognise gambling harm and know how to help

Investment aligned to this strategic priority will be focused towards:

1. Educating at-risk groups about risky gambling behaviour and how to keep themselves safe, gambling-related harm and the help available
2. Arming South Australians with the knowledge, resources and skills to minimise and prevent gambling harm
3. Delivering culturally and linguistically appropriate messaging about the impact of gambling harm on individuals, families and the community, and promote help seeking
4. Challenging negative community attitudes, common misconceptions and stigma about gambling products, behaviour and harm.

What should be monitored based on scientific literature?

Although certain individuals are likely to be at greater risk of gambling harm due to underlying individual characteristics or vulnerabilities (Blaszczynski & Nower, 2002), gambling products often incorporate design features that increase the probability of harm arising. These features have been summarised in a number of major reviews (e.g., Delfabbro & Parke, 2021; Dowling, Smith, & Thomas, 2005; Livingstone et al., 2008; Parke, Parke, & Blaszczyski, 2016), sociological analyses (Dow-Schull, 2012) and have been researched in a number of studies (e.g., Binde et al., 2017; Brosowski et al., 2020; Castren et al., 2018; Delfabbro & King 2021; Scalese et al., 2016).

Studies examining product risk generally show that exposure to online slot games or EGMs is associated with the highest risk gambling and that this type of gambling is most likely to be identified as the cause of gambling problems (Delfabbro et al., 2020a).

In summary, the literature indicates that future investment priorities under the Investment Plan should be mindful that certain activities are higher risk (i.e., EGMs), and that there are other products that may contain a higher proportion of at-risk gamblers (e.g., wagering).

In addition to understanding the riskiness of different gambling products, it is also important to examine the factors that might reduce or mitigate gambling risk. People also need to be educated about 'safe gambling' practices, which can be used to reduce the risk of gambling harm. Such strategies include setting clear limits on expenditure; balancing gambling with other activities; prioritising expenditure; stopping when ahead; not chasing losses; and, keeping track of how much is being spent (Hing et al., 2017).

Although the provision of objective information (e.g., brochures or posters), is not always understood or attended to by higher risk gamblers , such information can nonetheless enable people to make informed appraisals about the risks associated with gambling.

In this sense, such information may serve as a protective factor for people who are at the lower-end of the risk continuum. Important information that can be imparted through education, and which already forms part of many cognitive-behavioural treatment programs, relates to concepts of randomness and chance, erroneous beliefs, and common misconceptions and how the industry and gambling products work.

Several lines of emerging evidence also support the idea that children may also be at-risk of gambling harm due to the behaviour of adults in their life. Studies consistently show that young people, whose parents and/or siblings gamble, are statistically more likely to gamble themselves and to experience issues related to gambling.

Although adolescent gambling is not always predictive of subsequent adult gambling (Dowling et al., 2010), gambling at an earlier age (often without supervision) has been reported to increase the likelihood of higher-risk gambling in adulthood. This pattern is most common in young males who are more likely to develop an interest in wagering and betting on casino-style games at a younger age (Delfabbro, King, & Derevensky, 2016; Volberg et al., 2011).

Another important consideration is stigma. Stigma refers to the attribution of negative sentiments towards a particular entity, object or individual in the form of be emotional, cognitive, or specific behaviours directed towards individuals (Corrigan, 2004; Hing, Russell, Nuske, & Gainsbury, 2015).

Stigma is thought to have several important consequences. It can make the experience of gambling harm much worse in that people feel rejected and despised by others (Dabrowska & Wieczorek, 2020; Horsch & Hodgins, 2015), and this can lead to people becoming more socially isolated and likely to conceal their problems (Hing, Nuske, Gainsbury, & Russell, 2016; Hing & Russell, 2017a, b). 'Problem gambling' appears to be a highly stigmatised disorder.

Given the significance of stigma as a barrier to help seeking, Corrigan and Shapiro (2010) explored the measurement of stigma at a population level and examined past studies that had reviewed the effectiveness of stigma reduction programs for mental illness. Drawing on the evidence of Wahl (1995), the authors reviewed three different types of stigma reduction programs – 'Protest' campaigns (where offenders are chastised for discrimination), educational approaches and contact with people affected by mental illness.

Results highlighted that there was some anecdotal evidence for the effectiveness of 'protest' programs that highlight the injustices of stigma and chastise offenders for discrimination. However, some evidence was also identified that 'protest' campaigns can sometimes have a rebound effect where supressed prejudices can become worse (e.g., Macrae, Bodenhausen, Milne, & Jetten, 1994; Wegner, Erber, and Bowman, 1993).

Educational approaches that challenge stereotypes were also reviewed, with some positive effects identified. However, there was a caveat that interventions can sometimes lead to the public seeing people with mental illness as less responsive to treatment (i.e., as the condition is assumed to be 'hard-wired').

The third major approach reviewed involved people interacting with people with mental illness (i.e., contact). This was seen to have a potential positive benefit in reducing prejudice (e.g., Corrigan, 2005).

While it is unclear if such research translates to problem gambling stigma, it highlights that stigma reduction programs can be effective and have potential to be helpful to encourage help seeking in people experiencing gambling harm.

From this perspective, such issues highlight the importance of monitoring:

South Australian understanding of the harm of gambling and the risks of using specific gambling products including knowledge of how people can protect themselves and others from harm

The extent that South Australians talk to young people about the harms of gambling

The extent that South Australians show understanding for people harmed by gambling and are motivated to help and support people negatively affected.

Strategic priority 1:

South Australians recognise gambling harm and know how to help

The Key Result Areas (KRAs), Key Performance Indicators (KPIs) and Key Performance Measures (KPMs) developed for this strategic priority are summarised as follows.

Key Performance Indicators (KPIs)	Key Performance Measures (KPMs)	Methods
Key Result Area 1: South Australians understand the harm of gambling and protect themselves and others from harm		
KPI1. South Australians understand and recognise early signs of gambling harm.	• South Australians understand the continuum of gambling harm and recognise early signs of gambling harm across all life domains.	 Survey
KPI2. South Australians understand why gambling products can be harmful and know how to help and protect themselves and others from harm.	• South Australians have knowledge of harmful features of gambling products including those relevant to EGMs, sports betting and wagering & table games.	 Media metrics
KPI3. South Australians are aware of communications campaigns targeting gambling harm and communications campaigns are effective.	• South Australians understand and use evidence-based strategies to protect themselves and others from gambling harm. • Awareness, behavioural change and reach of communication campaigns.	
Key Result Area 2: South Australians talk to young people and children about the harms of gambling		
KPI1. South Australians talk with young people or children about the harms of gambling.	• Proportion of South Australians who talk with young people or children about the harms of gambling.	 Survey
Key Result Area 3: There is an increasing level of understanding in the South Australian public for people harmed by gambling		
KPI1. South Australians show understanding for people harmed by gambling and know how to help.	• Level of perceived stigma towards South Australians impacted by gambling harm. • Level of motivation of South Australians to personally provide help and support to people harmed by gambling.	 Survey

Preventing and intervening early in gambling harm

Investment aligned to this strategic priority will be focused towards:

1. Developing targeted prevention and early intervention initiatives for those groups most at risk of experiencing gambling harm
2. Building workforce capability and capacity for harm prevention and to recognise and intervene early in gambling harm, including among venue staff and allied services
3. Supporting communities to offer diverse, pro-social leisure activities as an alternative to gambling
4. Helping grow the evidence base for effective prevention and early intervention in gambling harm.

What should be monitored based on scientific literature?

Prevention and early intervention are the cornerstones of the public health approach to gambling harm.

Since the late 1990s, there has been an increasing focus on the value of public health approaches to reducing gambling-related harm (Korn & Shaffer, 1999; Shaffer & Korn, 2002; VRGF, 2015). The principal focus of this approach is to extend service and policy responses beyond harm reduction towards a greater emphasis on harm-minimisation and prevention.

The rationale behind this approach is that gambling, like other population-level behaviours, such as alcohol consumption, tend to occur on a continuum. There are a large number of people who engage in a low level of consumption (or not at all); a smaller group who consume the products more regularly; and, finally, a minority who experience very severe harms.

The idea that public health approaches could be applied to gambling arises from the observed success associated with reducing behaviours such as smoking or harmful alcohol consumption (Korn & Shaffer, 1999). To achieve these objectives, public health approaches emphasise the importance of primary prevention initiatives to target gambling harm in the wider community, and these approaches may be directed towards both people who gamble, and those who do not gamble.

By contrast, secondary approaches (addressed in other sections of this report) focus only on people who are at higher-risk of gambling harm, whereas tertiary interventions involve the provision of services to people already significantly harmed by gambling.

Prevention approaches are important for several reasons. First, they are designed to reduce the onset of higher risk behaviour. For example, if there are fewer gaming machines, or people are more aware of risks, or they play less often or less intensely, they will be less likely to develop problematic patterns of gambling.

A second important role for policy interventions is to reduce the normalisation of gambling that occurs through other activities (e.g., sport) and to encourage engagement and interest in a broader range of activities within communities. Allen Consulting Group (2011) reported that 61% of higher risk gamblers in Tasmania reported that they gambled to escape boredom, and this motivation has been reported in numerous Australian prevalence studies (Delfabbro, 2015).

For these reasons, it is not surprising to find that scheduling replacement activities, finding new activities, and making new social contacts is a central part of some treatment programs for problem gambling (Allcock & Dickerson, 1990; Blaszczynski, 1998). This also highlights that a key early intervention and prevention strategy for minimising gambling harm could involve encouraging gamblers to diversify their leisure interests and reduce their reliance on gambling as a social activity.

A second important requirement is for gambling venue staff to have knowledge, time and ability to intervene more proactively with patrons displaying indicators of gambling-related harm. Although some patrons may seek out the support of staff or disclose problems, many will not. For this reason, staff will often need to be alert to warning signs that people might be displaying problems. Three major Australian studies have examined this topic (Delfabbro et al., 2007, 2016; Thomas, Delfabbro, & Armstrong, 2013).

In addition to prevention in gambling venues, local communities in South Australia play a central role in managing public health and wellbeing. In South Australia, the *Public Health Act 2011 (SA)* makes all local government authorities responsible for public health within a local jurisdiction. Councils present as a particularly useful setting for screening and responding to gambling harm. Such initiatives highlight the potential for Gambling Help staff to work with councils and other community organisations within local government areas to build their capacity to identify (screen) and respond to gambling harm.

From this perspective, such issues highlight the importance of monitoring:

The confidence of GHS staff in prevention and early intervention activities

The number of community organisations screening for gambling harm, the effectiveness of their activities and their overall understanding of gambling harm

The extent that pilot programs can reduce reliance on gambling as a leisure activity.

Strategic priority 2:

Preventing and intervening early in harm

The Key Result Areas (KRAs), Key Performance Indicators (KPIs) and Key Performance Measures (KPMs) developed for this strategic priority are summarised as follows.

Key Performance Indicators (KPIs)	Key Performance Measures (KPMs)	Methods
Key Result Area 1: GHS staff and community organisations prevent and intervene early in gambling		
KPI1. GHS re-orient services to incorporate a stronger focus on prevention and early intervention of gambling harm. **KPI2.** GHS staff report confidence and skills in conducting prevention and early intervention activity to respond to gambling harm.	• GHS regularly report detailed information on prevention and intervention activities they are leading. • GHS staff report improved confidence and access to tools to support prevention and early intervention of gambling harm.	 Survey  GHS reporting
Key Result Area 2: Community organisations across South Australia prevent and intervene early in gambling harm		
KPI1. Community organisations across South Australia are engaged to conduct screening and/or low intensity treatment to respond to gambling harm.	• A number of community organisations and clients screened for gambling harm, treated and/or referred to GHS. • Community organisations better understand gambling harm since engagement by a GHS.	 GHS reporting
Key Result Area 3: Reduction of reliance of people at-risk of gambling harm on gambling as a leisure activity		
KPI1. People at-risk of gambling harm taking part in a pilot program to reduce reliance on gambling as a leisure activity report less frequent gambling and improvements in mental health and wellbeing.	• Number of participants identified at-risk of gambling harm engaged through the pilot program. • Improvements in mental health and wellbeing self-reported by pilot program participants.	 Survey

People get the right support at the right time

Investment aligned to this strategic priority will be focused towards:

1. Ensuring people experiencing gambling harm have access to a range of client-centred, culturally appropriate resources, services and support
2. Equipping loved ones with the knowledge and skills they need to engage in appropriate self-care and minimise harm
3. Establishing clear referral processes and pathways to and within the Gambling Help service system
4. Identifying and addressing system-level barriers to accessing and benefitting from Gambling Help services.

What should be monitored based on scientific literature?

As research suggests that many people harmed by gambling do not seek help (e.g., Loy et al., 2018), it is important that service systems actively promote services to ensure that people harmed by gambling can access the right type of support at the right time.

To this end, service systems across Australia have been designed to offer those negatively affected by gambling three main types of support: Gambling Help Services that provide therapeutic treatment and financial counselling; a telephone-based Gambling Helpline (1800 858 858) that refers clients to help services and provides brief interventions; and, Gamblinghelponline.org.au, which provides online 'live chat' counselling and many useful self-help and harm-minimisation resources.

Despite such services being the cornerstone of the national Gambling Help service system, many people remain unaware of available help services. For example, as indicated by unprompted questioning in the 2018 South Australian prevalence survey (Woods et al, 2018), only 29% of adults were aware of the Gambling Help Line and 1.2% were aware of Gambling Help Online (gamblinghelponline.org.au).

Accordingly, increased awareness may help ensure that a greater proportion of South Australians are aware of available help services (which may in turn increase service use by some individuals).

Furthermore, as stigma and shame are experienced by people affected by gambling, only a small proportion of people experiencing gambling harm access therapeutic treatment (Gainsbury et al., 2014). In addition, some people experiencing low level gambling harm may also not recognise the harm that their gambling is causing.

For this reason, screening for gambling harm across community settings has been identified as a means to ensure that people receive treatment and support for gambling issues (e.g., Manning et al., 2020). Gambling screening has been found to be of great value in many settings including in primary health care, alcohol and other drug and mental health services (e.g., Dowling et al., 2019) and also in other settings such as consumer credit (e.g., Sacco et al., 2019) and prisons (e.g., Castrén et al., 2019).

From this perspective, the total number of referrals to Gambling Help Services from across the community will provide evidence of the extent to which there is an integrated public health approach to identifying gambling harm across the population. Indeed, any treatment services that can help build the capacity of local community services to conduct screening for gambling issues is likely to encourage local help seeking.

Although tertiary services (including therapeutic treatment) are a cornerstone of public health approaches to gambling, research also indicates that not all types of treatment are equally effective. For example, based on a review of evidence from controlled trials of psychological interventions for the treatment of gambling problems, Ginley et al. (2019) found some differences in both the effectiveness of treatments and also the level of client attrition within treatment programs. Similar reviews are provided by the Joanna Briggs Institute (2018), Petry, Ginley, & Rash (2017) and Riberto, Afonso, & Morgado (2021).

Interventions reviewed included full-length therapies (e.g., cognitive behaviour therapy, cognitive therapy and behaviour therapy), self-directed and computer-facilitated programs, and motivational interventions (e.g., motivational interviewing, motivational enhancement therapy, personalised feedback). The review indicated that drop out from treatment was consistently high across programs and Cognitive Behaviour Therapy (CBT) was generally the therapeutic approach most well-supported by research evidence. In addition, Motivational Interviewing (MI) was identified as a useful technique in the context of therapy.

Support for Cognitive Behaviour Therapy (CBT) was also identified in an earlier Cochrane review of psychological therapies for the treatment of pathological and problem gambling (Cowlishaw et al., 2012). Eleven of the fourteen studies reviewed compared the effects of CBT with control groups at up to three months post-treatment and found medium to very large effects of the therapy.

Outcomes measured over time included changes in financial losses from gambling and changes in gambling symptom severity. Only one study compared groups at 9 to 12 months and no significant differences were noted. Accordingly, this highlights the importance of measuring changes in gambling behaviour and measuring the effectiveness of therapeutic treatment to ensure that those harmed are receiving the most effective treatment services, meet their therapeutic goals and complete their full treatment program (i.e., do not drop out of treatment).

From this perspective, such issues highlight the importance of monitoring:

Where GHS clients come from by source

The extent that GHS achieve therapeutic goals and whether services are effective (and retain clients)

The extent that South Australians are aware of help services and resources to minimise harm.

Strategic priority 3:

People get the right support at the right time

The Key Result Areas (KRAs), Key Performance Indicators (KPIs) and Key Performance Measures (KPMs) developed for this strategic priority are summarised as follows.

Key Performance Indicators (KPIs)	Key Performance Measures (KPMs)	Methods
Key Result Area 1: Number of clients identified by the Gambling Helpline, Gambling Help Online, Industry and the community		
KPI1. Number of clients received from different sources including the (a) Gambling Helpline (b) Gambling Help Online (c) Industry (d) the community.	• Number of client referrals by source.	 Client Data set
Key Result Area 2: Gambling Help Services achieve therapeutic goals, reduce gambling harm and retain clients in treatment		
KPI1. GHS clients show improvements in gambling behaviour. **KPI2.** GHS clients 'fully' or 'substantially' reach their therapeutic goals at the conclusion of treatment. **KPI3.** GHS clients fully complete their treatment. **KPI4.** GHS clients maintain recovery after treatment.	• Gambling behaviours improve within GHS clients to reduce gambling harm. • Proportion of GHS clients reaching their therapeutic goals at treatment conclusion. • Proportion of GHS clients fully completing their treatment at GHS. • Proportion of GHS clients maintaining their recovery.	 Client Data set
Key Result Area 3: Access to help and awareness of available services and resources to minimise gambling harm		
KPI1. South Australians are aware of the Gambling Helpline, Gambling Help Online and services and resources. **KPI2.** South Australians are aware that help resources to address gambling harm are available online. **KPI3.** South Australians harmed by gambling are getting the help they need - whatever the source (e.g., family, friends, GHS, other service).	• Awareness of the Gambling Helpline, Gambling Help Online, South Australian GHS including CALD and Indigenous services. • Awareness of South Australian resources developed to minimise gambling harm. • South Australians harmed by gambling received the help they needed to reduce gambling harm and help was provided before a crisis.	 Survey

4

An agile system equipped to identify, prevent and respond to emerging harm and need

Investment aligned to this strategic priority will be focused towards:

1. Partnering with the regulator, help services and industry to create safer gambling environments
2. Contributing to local and national efforts to design and implement coordinated action to prevent and minimise gambling harm
3. Disseminating information and research to empower community participation in debate around gambling harm and decision-making at the local level
4. Funding and promoting research to inform gambling harm prevention and minimisation policy, initiatives and decisions.

What should be monitored based on scientific literature?

The gambling environment continues to evolve and change in response to, inter alia, government regulation, new technologies and new products. There is no better example than the growth in sports betting, the ever- expanding range of products on offer, the growing investment in advertising across traditional and digital platforms, and the technology to engage in sports betting (Killick & Giffifths, 2019). This emphasises the need for an agile and responsive policy, program and regulatory environment to ensure that service providers, policy makers and regulators keep track of the changes and can work together to deliver effective harm-minimisation services.

As the gambling environment continues to change, so too have responses to gambling, and strategies for harm-minimisation. Increasingly, gambling is identified as a public health issue since the harms from gambling affect a much broader population than the individual gambler, with estimates suggesting that the impacts of a problem gambler may spill over to 5-10 others (Productivity Commission, 2010).

In practical terms, the change in emphasis highlights a need for re-orientation of policy, programs and funding (i.e., resource allocation) towards prevention for the whole community, involving education, awareness and early intervention for those known to be most at-risk of gambling harm.

An agile system will reflect this change in emphasis through the development of evolving public policies, legislation, regulation, and taxation, in efforts to achieve a reduction in demand or curtail supply. Such initiatives involve multiple diverse stakeholders including both funding bodies (e.g., OPG) and regulators (e.g., Consumer and Business Services) working together to develop effective strategies to minimise gambling harm.

Collaboration is also needed at a service provider and funder level. In particular, the South Australian Gambling Help services system offers a diverse range of services and it is important to ensure that the service system can be sufficiently agile to meet client needs. Importantly, this also includes strong and collaborative relationships between industry and treatment services and industry and regulators.

The current service system includes:

- the 24/7 Gambling Helpline which provides counselling, information and referral services for South Australians adversely affected by gambling problems
- an intensive therapy service which provides state-wide access to intensive treatment, such as Cognitive Behaviour Therapy, as well as follow-up and relapse prevention
- Aboriginal and culturally and linguistically diverse (CALD) gambling help services which provide primary, secondary and tertiary interventions to address gambling problems within the relevant community
- a criminal justice gambling help service which provides holistic support to gamblers involved in the criminal justice system
- support for people with lived experience of problem gambling to share their story in public forums to educate and increase awareness of gambling harm.
- Regional Metropolitan and Country Gambling Help Services – This includes 12 services to provide services across the whole state.

The diversity of such programs and services illustrates the need for collaborative approaches that follow evidence-based best practice.

Other jurisdictions have repeatedly demonstrated the benefits of collaboration between different stakeholder groups. For example, a case study in Macao (Siu Lam, 2022), involving an informal partnership between a public university and a Gaming Service Provider, resulted in clear benefits to both parties (i.e., knowledge transfer and learnings to both parties). Moreover, the role of the Macao Government in brokering and enhancing this collaboration was key to its success. Whilst Siu Lam (2022) acknowledges that such partnerships can be time-consuming, and require considerable efforts from all parties, learnings from such early adopters can be used to inform future protocols and working structures.

Knowledge Translation (KT) is a further fundamental tenet of collaborative relationships and an essential component of an agile system. It is defined by the World Health Organisation (2018) as - 'The synthesis, exchange, and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health' . And, more colloquially and succinctly by the Research Impact Academy (2018; previously Knowledge Translation Australia) as: 'Getting the right information, to the right people, at the right time, and in a format they can use, so as to influence decision making'.

As the OPG increasingly invests in gambling research, there is great potential to ensure that all research insights are disseminated widely and that checks and balances are in place to ensure that the right stakeholders receive the right information at the right time. As Gambling Help Services are at the forefront of gambling harm-minimisation, it is particularly important that GHS have access to translated knowledge and information with potential to improve their service delivery.

From this perspective, such issues highlight the importance of monitoring:

Quality of relationships and collaboration with key service system stakeholders

The dissemination of research in formats that stakeholders can use and operationalise

The extent to which research investment is used to undertake ongoing improvements in the

South Australian gambling harm-minimisation service system.

Strategic priority 4:

An agile system equipped to identify, prevent and respond to emerging harm and need

The Key Result Areas (KRAs), Key Performance Indicators (KPIs) and Key Performance Measures (KPMs) developed for this strategic priority are summarised as follows.

Key Performance Indicators (KPIs)	Key Performance Measures (KPMs)	Methods
Key Result Area 1: Quality and outcomes of work undertaken by OPG with key stakeholders to foster a collaborative and agile approach to harm minimisation in South Australia		
KPI1. Quality and outcomes of work of OPG to partner with the (a) regulator, (b) help services and (c) industry to prevent and reduce gambling harm.	• The quality of relationship with stakeholders. • The effectiveness of work and collaboration with stakeholders.	 Business metrics
Key Result Area 2: Commissioning, funding and dissemination of applied research to inform gambling harm-minimisation		
KPI1. Quality of knowledge translation and dissemination of GRF-funded research findings to inform the practices of key stakeholders in gambling harm-minimisation.	• All fact sheets from research reports are published on the OPG website and describe practical applications of findings for South Australian context.	 Survey
KPI2. Commissioning of and completion of research projects against priority topics to improve gambling harm-minimisation in South Australia and inform GRF-funded activities and state-wide policy.	• Investment in research aligns to strategic priorities of the investment plan and research can be used to further improve the South Australian gambling harm-minimisation service system.	

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